Hyde County School Health Program
Medical History Update Form

Fill out completely and return to the school nurse for the 20-21 school year.

Student's Name: ______________________________ **Date of Birth: ___________________________**
Grade/Teacher________________________________ **Bus #: _________________________________**

EMERGENCY CONTACT INFORMATION
Parent/Guardian Name: ________________________ Phone: _________________________________

Parent/Guardian Name: ________________________ Phone: _________________________________

Persons to contact if Parent/Guardian can not be reached:
Name: ________________________ Relation to child: ______________ Phone: __________________
Name: ________________________ Relation to child: ______________ Phone: __________________

Complete the following checklist and give details below attaching any additional pertinent information. This is confidential information and will be used by the school nurse and professional staff only.

Does the student currently have, or in the past had any of the following conditions? Y/N

Condition	Y/N	Condition	Y/N
Allergic to:		Hearing Loss / Wears hearing aid	
ADHD/ADD		Heart Condition/Murmur Name of Problem:	
Anemia (including Sickle Cell)		Lead Poisoning	
Arthritis		Lung Disease/Tuberculosis	
Asthma Triggers:		Medication Reaction/Allergy:	
Back/Neck Injury		Mononucleosis (Mono)	
Bladder/Kidney Disease		Orthopedic/Bone Problems or Fractures	
Bleeding/Clotting Disorder		Psychological/Psychiatric Treatment	
Cancer/Leukemia		Surgery (Describe Below)	
Convulsions/Seizures/Epilepsy		Speech Problems	
Diabetes or Hypoglycemia (low blood sugar)		Depression	
Head Injury/Concussion Date:		Vision / Wears glasses or contacts	
Headaches/Migraines		Cystic Fibrosis	
Hepatitis		Other	

Give details for all the above checked items:

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Continue on back…..

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List any medications, including inhalers; the student is taking on a regular basis.

Medication Name:	Dose:	Times:	Reason for Taking Medication:	Prescribing Physician:	Need to take at school?
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No

Health Care Provider Information

Date of last Physical Exam: ______________ Physician: ______________________ Phone: ________________
Date of last Dental Exam: _______________ Dentist: ________________________ Phone: ________________
Date of last Eye Exam__________________ Ophthalmologist: _________________ Phone: ________________

I authorize Hyde County School Health Personnel to obtain health related information regarding my child from the above named Healthcare Providers as needed for the purpose of maintaining an optimum state of wellness conducive to learning. ____

(Parent Signature) **(Date)**

Health Insurance Information

Is your child covered by health insurance? Yes / No
Is your child covered by Medicaid? Yes / No
Is your child covered by Health Choice? Yes / No
Is your child covered by dental insurance? Yes / No